Montana Strategic Suicide Prevention Plan

The Montana Department of Public Health and Human Services

January, 2001

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The State Strategic Suicide Prevention Steering Committee

Critical Illness and Trauma Foundation, Inc.

The Montana Mental Health Association

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SUICIDE PREVENTION IN MONTANA: A 5-YEAR PLAN

Introduction

Suicide persists as a major public health problem in Montana.[1] There are many individuals and organizations that are working to address this issue. These include: survivors, youth, law enforcement officers, tribal members, mental health professionals, health care providers, community volunteers, schools, not-for-profit agencies, spiritual leaders, clergy, state, local and federal government officials, and many others.

The individuals and agencies that are currently addressing suicide often do so from their own unique perspective and to meet their own special needs. To date, there has been no statewide, strategic effort to link these many assets together and to build a stronger network of resources to address suicide as a major statewide public health priority.

In the Spring of 2000, the Montana Department of Public Health and Human Services invited a group of private organizations, concerned citizens and government officials to begin the development of a statewide plan for suicide prevention. With consultation from international experts in suicide prevention, the Montana Suicide Prevention Steering Committee began work that led to the development of this statewide strategic plan. This document is the result of the initial planning effort and outlines a 5-year strategic direction and an action plan for the next 12 months. The Steering Committee intends that each year it will review progress against the plan and establish strategic priorities for the succeeding 12 months.

Suicide – The Magnitude of the Problem

United States

Overall, suicide rates have remained fairly stable over the last 20 years. However, increases in the rates of suicide among certain age, gender, and ethnic groups have changed. Suicide rates among adolescents and youth in some areas of the nation have increased dramatically. At the other end of the age spectrum, suicide rates remain the highest among white males over the age of 65. Differences are also occurring in some racial groups with the rates of suicide among young African American males showing significant increases.

Suicide is a serious and complex issue. In 1998, suicide was the 8th leading cause of death in the United States accounting for nearly 31,000 deaths.[2] This number is 50% higher than the number of homicides during that same year.[2]

Approximately 500,000 people a year in the United States require emergency room treatment as a result of a suicide attempt.[3] Suicide has a devastating and, often lasting, impact on those that have lost a loved one as a result of suicide. While suicide rates in the U.S. place it near the mean for industrialized nations, the rates within the U.S. are highly variable by region and state.[4] The intermountain western states have the highest rates of suicide as a region and Montana ranks persistently near the top of the rate chart annually.

Montana

Unfortunately, Montana's suicide rates are among the highest in the nation. For the past fifteen years we have not fallen out of the top three rankings. Often we are number two on the yearly charts second only to Nevada. This is not a new trend. It dates back to the earliest recorded data concerning suicide in the U.S.[4] However, what is noticeable from Figure 1 is that the rate continues to creep upward over time.

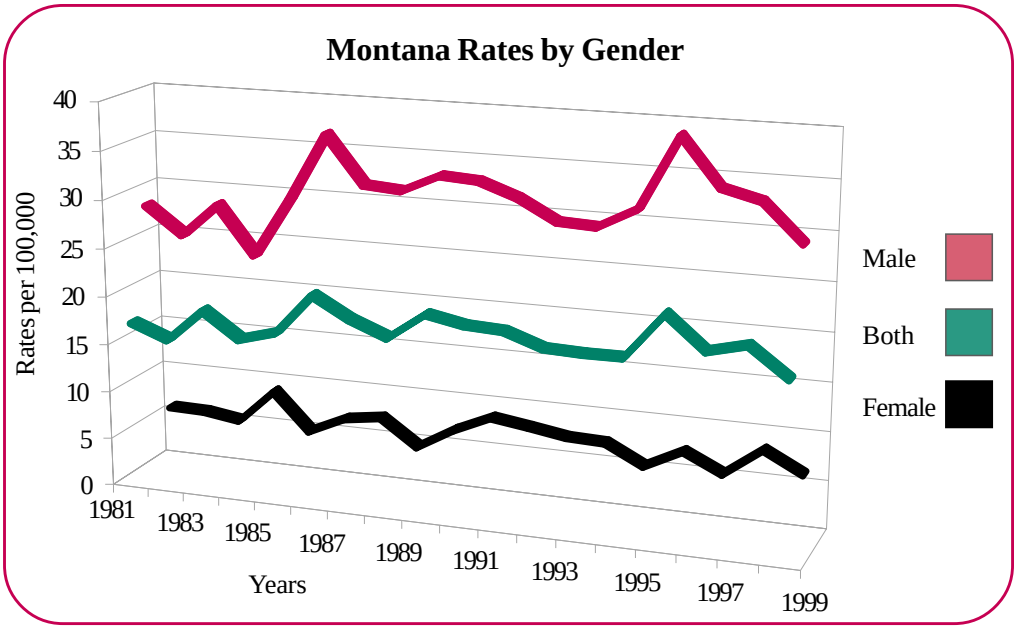

Figure 1

Gender

Montana is consistent with the rest of the U.S. in that suicide deaths vary by gender with males at greater risk than females. Figure 1 documents the differences in risk of suicide by gender.

Race

Suicide in Montana also varies, to some degree, by race. The small population of American Indian [†] residents in Montana result in highly variable rates by year. A small increase in the actual numbers of deaths can have, what appears to be, a catastrophic impact on the rate for that year. In reality, the difference in rates between American Indians and Caucasians in Montana is minimal when considered over time. Unfortunately, both rates are much too high. Figure 2 documents the similarities in rates by race.

[†] The term American Indian is used throughout this document with the greatest respect for the indigenous people of Montana. We acknowledge that some nations, bands, tribes, clans and individuals prefer other nomenclature including Native Americans, First Nations and indigenous people. The term American Indian was selected based upon the majority input received by Native representatives on the steering committee and is used exclusively throughout the document to provide continuity.

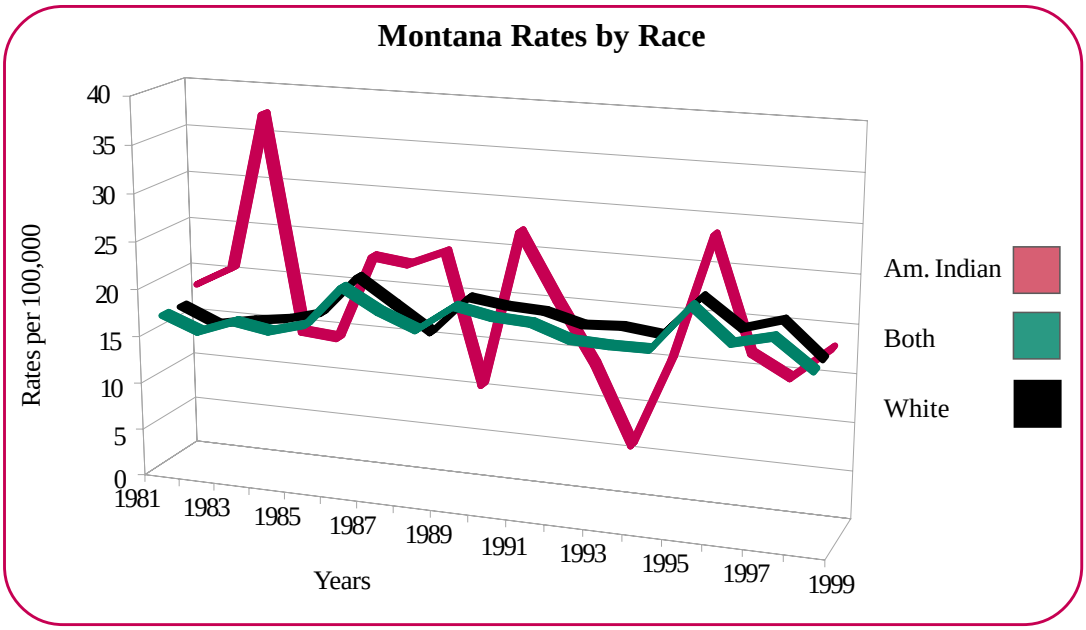

Figure 2

While Figure 2 does not break down the American Indian population into the various subdivisions of nations, tribes, bands and clans, for any given time period there is a high degree of variability among these classifications, just as there is similar variability among the Caucasian population when stratified by counties, cities and towns. What is clear from Figure 2 is that it is important to track the rates of suicide over time since any one year period may demonstrate marked deviation from the mean.

Age

Suicide rates in Montana vary widely by age. When all ages are combined, suicide has ranked as the 7th or 8th leading cause of deaths for Montanans for more than two decades. However, when those rankings are broken down further by age group the risk of suicide varies considerably. In Table 1 the magnitude of the threat from suicide for adolescents and young adults, as well as older Montanans becomes readily apparent. What is truly disturbing is that, for Montana's children and teens, suicide is among the leading causes of death.

Lethal Means

A number of means are used in the act of suicide in Montana. Of these, firearms and hanging are the most common. Other lethal means include: carbon monoxide, overdose, motor vehicle crashes, jumping from heights, etc. Figure 3 verifies the preponderance of firearms and hanging in Montana suicides.

When all ages are combined, suicide has ranked as the 7th or 8th leading cause of deaths for Montanans for more than two decades. What is truly disturbing is that, for Montana's children and teens, suicide is among the leading causes of death.

10 Leading Causes of Death, Montana
1998, All Races,
Both Sexes

Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	>85	Total
1	Congenital Anomalies	Unintentional Injury and Adv. Effects	Unintentional Injury and Adv. Effects	**Suicide**	Unintentional Injury and Adv. Effects	Unintentional Injury and Adv. Effects	Unintentional Injury and Adv. Effects	Malignant Neoplasms	Malignant Neoplasms	Malignant Neoplasms	Heart Disease	Heart Disease	Heart Disease
2	SIDS	Congenital Anomalies	Diabetes	Unintentional Injury and Adv. Effects	**Suicide**	**Suicide**	Heart Disease	Heart Disease	Heart Disease	Heart Disease	Malignant Neoplasms	Malignant Neoplasms	Malignant Neoplasms
3	Maternal Complications	Bronchitis Emphysema Asthma		Bronchitis Emphysema Asthma	Homicide & Legal Int.	Malignant Neoplasms	Malignant Neoplasms	Unintentional Injury and Adv. Effects	Bronchitis Emphysema Asthma	Bronchitis Emphysema Asthma	Bronchitis Emphysema Asthma	Cerebro-vascular	Cerebro-vascular
4	Placenta Cord Membranes	Homicide & Legal Int.			Malignant Neoplasms	Heart Disease	**Suicide**	**Suicide**	Unintentional Injury and Adv. Effects	Cerebro-vascular	Cerebro-vascular	Pneumonia & Influenza	Bronchitis Emphysema Asthma
5	Unintentional Injury and Adv. Effects	Malignant Neoplasms			Congenital Anomalies	Congenital Anomalies	Liver Disease	Liver Disease	Cerebro-vascular	Diabetes	Pneumonia & Influenza	Bronchitis Emphysema Asthma	Unintentional Injury and Adv. Effects
6	Birth Trauma				Heart Disease	Homicide & Legal Int.	Cerebro-vascular	Cerebro-vascular	Diabetes	Unintentional Injury and Adv. Effects	Unintentional Injury and Adv. Effects	Alzheimer Disease	Pneumonia & Influenza
7	Homicide & Legal Int.				Benign Neoplasms	Benign Neoplasms	Diabetes	Diabetes	Liver Disease	Pneumonia & Influenza	Diabetes	Unintentional Injury and Adv. Effect	Diabetes
8	Pneumonia & Influenza				Cerebro-vascular	HIV	Homicide & Legal Int.	Bronchitis Emphysema Asthma	**Suicide**	Liver Disease	Alzheimer Disease	Diabetes	**Suicide**
9	Short Gestation				Complicated Pregnancy	Liver Disease	Bronchitis Emphysema Asthma	Homicide & Legal Int.	Pneumonia & Influenza	Nephritis	Nephritis	Nephritis	Alzheimer Disease
10	Five Tied				Pneumonia & Influenza	Two Tied	Septicemia	Benign Neoplasms	Ulcer	Septicemia	Two Tied	Athero-sclerosis	Nephritis

Table 1

Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC
Data Source: National Center for Health Statistics (NCHS) Vital Statistics System.

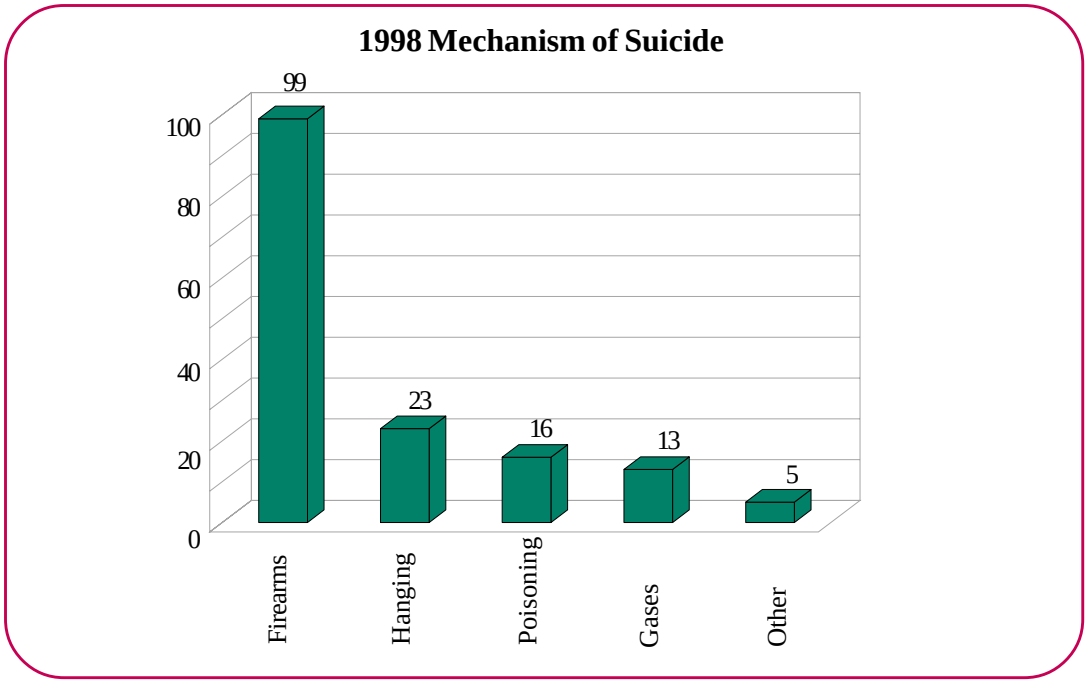

Figure 3

Opportunities for Prevention Activities

The variations in suicide rates by age groups and gender provide a wide array of opportunities for prevention and intervention activities. Prevention strategies can cover a wide variety of target groups (e.g., population at large, those who have ever thought of suicide as an option, those who have made previous attempts at suicide, and those in immediate crisis who are contemplating suicide). Such activities can also range from a broad focus such as addressing risk and protective factors to a more narrow focus such as preventing imminent self-harm or death. Although the data on effectiveness of various programs and interventions is limited, certain strategies are beginning to emerge as more effective than others.[5] What is clear is that a singularly focused intervention strategy such as a crisis line or gatekeeper training program will not have a lasting impact in isolation. Each program needs to be tightly integrated and interlinked with other strategies to reach the broadest possible range of persons at risk.

Protective Factors

Some individuals and communities are more resistant to suicide than others. Little is known about these protective factors. However they might include genetic and neurobiological makeup, attitudinal and behavioral characteristics, and environmental attributes. According to the Surgeon General's Call to Action to Prevent Suicide,[5] protective factors include:

- Effective and appropriate clinical care for mental, physical and substance abuse disorders.
- Easy access to a variety of clinical interventions and support for help seeking.
- Restricted access to highly lethal methods of suicide.
- Family and community support.
- Support from ongoing medical and mental health care relationships.
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes.

- Cultural and religious beliefs that discourage suicide and support self-preservation instincts, including American Indians practice of non-separation of culture, spirituality, and/or religion

As with prevention and intervention activities, when programs to enhance protective factors are introduced, they must build on individual and community assets. They must also be culturally appropriate. As an example, protective factors enhancement, in any one of Montana's American Indian communities must capitalize on the native customs and spiritual beliefs of that nation, tribe or band.

The Vision

The Montana State Strategic Suicide Prevention Steering Committee is hopeful this plan will make a major difference in the lives of Montanans. The plan is built on the strong belief that individuals and groups that address the physical, psychological, emotional, and spiritual needs of individuals and communities in Montana must work together to effectively address the suicide epidemic. With this in mind, the Steering Committee developed the following vision statement:

> *Montanans value human life. We encourage our citizens and organizations to deal openly, collaboratively and with sensitivity towards all cultures to minimize suicide as a choice. We are working to create a state where no person will be alone – where everyone will have access to qualified resources for help when they need it.*

The Mission

Suicide is a very complex issue. There are many factors that predispose an individual to suicide. Likewise, there are many potential points of intervention. However, the mission of the Strategic Suicide Prevention Steering Committee and of this plan is very straightforward.

> *Concurrent with the full and ongoing implementation of this plan, there will be a sustained reduction in the incidence, prevalence and rate of suicide and non-lethal suicidal behavior in Montana.*

Goals

To accomplish our mission and move toward the realization of our vision, there are several key goals which must be accomplished including:

1. *Increasing public awareness and concern around the issue of suicide as a leading cause of death and significant public health problem in Montana.*

2. *Dedicating sufficient personnel and fiscal resources to address the issue of suicide prevention activities in a structured and long-term fashion.*

3. *Linking and expanding data collection systems in Montana to provide for better tracking of suicide, non-lethal suicidal behavior and their consequences.*

The Environment for Suicide Prevention in Montana

The State Strategic Suicide Prevention Steering Committee has identified factors that could impact the implementation of this plan. These factors include: assets that could have a positive and supportive impact on the implementation of the plan; barriers and challenges to carrying out the plan; and finally, near term opportunities that could be leveraged to aid in the successful implementation of the plan.

Assets

A Sense of Community

- Many communities are addressing the suicide problem as a community, rather than an individual problem. These communities are large and small, Caucasian and American Indian and are scattered across the vast geographic expanses of the state.
- Many citizens are willing to get involved.
- Many community leaders are supportive and committed to the issue.

Montana's Small Population

- Our small population provides an opportunity for greater connection and networking.
- The suicide prevention plan can impact the whole state.

Existing Infrastructure and Resources

- There are established injury prevention coalitions in many communities. Including intentional injuries like suicide within the scope of these coalitions offers a sound basis for community participation and involvement.
- Models of multi-disciplinary problem identification and evaluation teams already exist at both community and state levels, i.e., the Montana Fetal, Infant, Child Mortality Review Committee, the Montana State Trauma Care Committee, etc.
- The Suicide Prevention Research Center at the University of Nevada's School of Medicine, recently funded by the Centers for Disease Control and Prevention, is prepared to provide suicide prevention research support to Montana.

There are many services and programs in place that could be enhanced to better address the needs of those at risk for suicide.

The Suicide Prevention Steering Committee Members, Individually and Collectively

- Can and will advocate for the full implementation of the suicide prevention plan.
- Will serve as an information resource to their communities.
- Serve as a network to provide support and resource information to each other.

Barriers

Infrastructure and Resources

- There is a lack of dedicated funding for the implementation of a plan.
- An urgent need exists for more professionals and volunteers who are better trained in issues of suicide.

- There is a reluctance to reallocate existing resources to suicide prevention efforts.
- Restricted funds from federal or state agencies cannot be reallocated for suicide prevention activities.
- Suicide prevention competes with other public health issues for limited resources.
- Some community organizations have limited funding for suicide prevention and yet they don't have sufficient, full-time, trained staff dedicated to the issue. Therefore, it becomes one of several priorities for already overburdened human service professionals.

Attitudes

- To date there has been a lack of community awareness and acceptance of the problem.
- The debate continues in some groups about whether suicide is an individual or community problem. It is, for some, easier to tackle the "individual" problem (acute care or after the fact intervention) and more difficult to take on the "community problem" (primary prevention and encouraging protective factors).
- There is a lack of cultural awareness and sensitivity by suicide prevention staff and in prevention materials and programs.
- In many communities there is insufficient expertise and capacity and often they must rely on expertise from outside of the local community to guide plans and activities. This lack of local capacity may result in the purchase of commercial products and programs that are without proven efficacy.
- The actual number of suicides within a given community is low; therefore the problem is easy to ignore or dismiss.
- Sustaining interest in suicide prevention activities is difficult after a crisis situation (a completed suicide) fades into the distant past.
- Changes in leadership often means changes in public health agendas and priorities.

A social stigma is attached to suicide that promotes silence, apathy and disinterest in the issue.

Montana's Unique Characteristics

- Much of Montana epitomizes geographical isolation, accentuated by the harsh winter climate.
- There is an ingrained social culture that has accepted suicide as a part of life in Montana since the arrival of the earliest white settlers.
- Montana's rate of suicide has proven resistant to change from previous prevention efforts.
- There is a lack of availability and access to mental health services in many areas in the state.
- There is a prevalent and proud "western" culture and attitude among the Caucasian majority in Montana - 'we can take care of ourselves.'
- In some homes there is access to firearms that are not properly stored.
- There is a lack of transportation services for some people that inhibits their ability to seek or receive help.

- There is a lack of communication infrastructure (phones, cellular service, Internet access) in some areas, including American Indian reservations, frontier and rural areas.
- Montana ranks high in alcohol and substance abuse when compared to other states in the U.S.

Some studies suggest there is a correlation between the rates of alcohol consumption and suicide.[7,8,9]

Health Communication

- It is currently difficult to retrieve data and to articulate and obtain support for the "intangible" benefits of suicide prevention. Because of this we have, in the past, tended to abandon primary prevention efforts in favor of crisis management and after the fact intervention (postvention).
- Suicidology is often laden with jargon and terminology that is foreign and intimidating to organizations and people not directly connected to the suicide prevention field.
- There is a lack of communication among local and state resources, prevention services and health professionals.

Near Term Opportunities

- The completion of this plan coincides with both an election year and a legislative session. These events provide an opportunity to raise awareness and encourage Montana's elected officials to be supportive of suicide prevention efforts.
- The Surgeon General's Call to Action to Prevent Suicide report has created new opportunities for the state and communities to apply for federal funding for suicide prevention activities.
- The youth suicide rate is a performance measure for the Montana Department of Public Health and Human Services. Therefore, increased priority will be placed on activities that support achieving this measure.
- The federal government's Healthy People 2010 goals include a goal of reducing disparities in all health-related issues to zero and includes suicide specific goals that serve as a basis for supporting action at the state level.

5-Year Strategic Directions and Current Year Priorities

The Steering Committee identified more than 30 strategic directions to consider over the next 5 years. These were prioritized to determine those to be addressed by collective, statewide action over the initial year of the plan's implementation. Specific action plans for these three are found in detail below. The remaining strategic directions are also listed for both reference during future planning and to encourage interested organizations and individuals to take action on them in the interim.

Current Year Priorities

Priority 1

Establish a central resource for accessing technical assistance, training, 'best practices' information, and updated listings of community resources. This resource should make use of modern communications technology (e.g., websites, teleconferences) to provide access to available information.

Definition: The central resource collects knowledge about existing resources and services and how to access them. It is not a service delivery (e.g., crisis intervention) program. The resource would serve as a gateway to quality materials, information, resources and training opportunities provided by other organizations and programs. An important component of the resource will be a computerized Montana community resource list, which will be updated on a timely basis. Another component would provide access to a central data repository (potentially located at the DPHHS) that would combine all Montana specific statistical data on suicide. Ultimately, access to the information available through the resource will require ongoing promotion to stakeholders and the public.

The central resource collects knowledge about existing resources and services and how to access them.

1-Year Action Steps

- Explore opportunities and identify sources of funding for this type of resource.
- Convene a subcommittee of statistical data stakeholders.
- Identify and approach existing resource centers in the state to act as an interim vehicle for holding the initial information collected.
- Engage CDC's Suicide Prevention Research Center in a dialogue about what is needed for Montana as identified in this plan.
- Establish a needs assessment subcommittee. The subcommittee would be charged with establishing a mechanism and process for gathering, storing and updating data on suicide prevention resources throughout the state. Subcomponents of this include:

    1. Develop the capacity and process for collecting information concerning suicide in Montana. A case statement should be developed that clearly articulates the benefits of individual, group and community participation in providing information.
    2. As a part of the information collection process, promote throughout the state, the use of a standardized reporting form.
    3. Identify a source for collecting and analyzing the information gathered in order to identify gaps and needs in suicide prevention data and activities.

Expected Outcomes

Identify committed people and organizations that are willing to give time and/or other resources to support the one year actions in this priority item. Commitment for the following areas will be secured.

- An organizer/convener of committee.
- Potential funding agencies.
- Identify and confer committee participants.
- Development of a catalog of community resources.
- The development of a repository of suicide information and data.
- A catalog of Montana stakeholders in suicide prevention from each county.

- A form, process and protocol for gathering information on community resources in order to develop the community resource catalog.
- Achieve consensus on common definitions and approaches for collecting data.
- Develop an interim report that combines the current statistical data on suicide in Montana.
- If possible, assemble the information from state agencies on programs and services that relate to suicide prevention.

Resources Required/Responsibilities

- Organizations willing to convene committees/working groups.
- Individuals who volunteer to participate on committees/working groups.

Priority 2

Provide for a statewide crisis hotline accessible to every Montana citizen by telephone.

Definition: The suicide hotline will be accessible to everyone in the state of Montana. It will provide direct counseling and referral services to persons at risk for suicide, survivors, and people who know people who are at risk. It does not provide information and technical resources (see Priority 1). The suicide hotline should be developed as an expansion of an existing service and not be created as a new, independent service. A quality hotline must meet strict standards in its management, operations, staffing, quality assurance and evaluation such as the suicide hotline certification criteria of the American Association of Suicidology.[10]

The suicide hotline will be accessible to everyone in the state of Montana.

1-Year Action Steps

- Identify existing state and regional services that are, or could, provide a suicide hotline service.
- Convene the above existing services to explore and discuss how best to approach the need for a suicide hotline in Montana.
- Identify the hotline standards and specifications (training requirements, certification, quality assurance methods, marketing, etc.) for the service and resource requirements.

Expected Outcomes

- A meeting with the representative of existing state and regional services will be convened.
- The specifications and resource requirements for a suicide prevention hotline will be established.

Resources Required / Responsibilities

- Organization(s) to convene a working group of existing state and regional services and a subcommittee to develop final specifications and resource requirements.

Priority 3

Develop a grassroots network/system for delivering information to large numbers of citizens and encouraging their involvement in specific actions that promote suicide prevention.

Definition: An established plan and methodology for obtaining grassroots (local citizens) support for suicide prevention activities and information delivery. The grassroots network reaches large groups of people, fosters two-way communication (communities to state level and state level to communities), provides for delivery of suicide prevention information, gathers pertinent community information and establishes, maintains and grows community support for suicide prevention. While grassroots development is essential, it should not occur (except as noted below) until the infrastructure action steps from Priorities One and Two have been accomplished.

The grassroots network reaches large groups of people, fosters two-way communication, provides for delivery of suicide prevention information, gathers pertinent community information and establishes, maintains and grows community support for suicide prevention.

1-Year Action Steps

Plan a conference for early in year 2 of the plan to train interested people on how to discuss and advocate for suicide prevention efforts in their own communities. Participants of the conference would represent diverse stakeholders (health care professionals, members of the Suicide Prevention Advocacy Network (SPAN), other survivors, community leaders, etc.).

Take a systematic approach to reach established organizations that have complementary interests, (health, voluntary organizations, community development, etc.) to get suicide prevention messages and education about the issue on meeting agendas.

Expected Outcomes

- A written plan and identified dates for a suicide prevention conference.

Resources Required / Responsibilities

- An organization to convene a group of people to organize and develop a suicide prevention conference.

Additional 5-Year Strategic Directions

- Raise the awareness of school leaders on existing state protocols for handling tragic deaths and train them on their use and how to access supporting services.
- Assure education and open discussion of general issues associated with death and dying.
- Broaden the involvement of people and organizations throughout the state who are potential stakeholders/interveners in suicide prevention (e.g., tribal elders and spiritual leaders, clergy, business communities, bartenders, hairstylists, home visitation programs, AARP).

Engage the elderly, tribal elders, spiritual leaders, parents, clergy, and mentors as peers for each other, as 'senior' mentors for youth, and as public advocates for suicide prevention efforts.

- Provide rapid response interventions (e.g., crisis intervention teams) to assist people in communities where a suicide has occurred.
- Inform the media and others who convey public information on existing 'guidelines' for reporting suicides with sensitivity rather than sensationalism.
- Provide education and services through school settings.
- Promote awareness of the issue and suicide prevention among legislators and other elected officials.
- Proclaim a Suicide Prevention Week to raise awareness of the issue and provide updated information on services.
- Improve access to, and capacity of, mental health services.
- Integrate efforts among other programs, agencies and prevention plans in the state.
- Develop a policy agenda for use at both the state and local levels.
- Market and promote awareness of suicide as a public health problem and suicide prevention among Montana's citizens.
- Promote the development of community suicide prevention action plans.
- Assure multi-disciplinary coordination and collaboration for suicide prevention.
- Inform providers in the state on current liability and confidentiality laws and issues related to suicide prevention.
- Create a formal survivor network.
- Improve data collection systems, including evaluation and reporting services.
- Develop targeted interventions for populations with elevated risks and/or specific needs (e.g., for American Indians).
- Promote access to parenting classes that emphasize building self-esteem from the earliest ages.
- Conduct a 'social norm' change campaign (perhaps in conjunction with other social marketing campaigns currently underway). This campaign would emphasize the fact that most people in Montana don't consider suicide an option, even under the most dire of life's circumstances.
- Establish community 'standards' for suicide prevention efforts.
- Train mental health and other professionals on suicide prevention.
- Engage people in community service related to suicide prevention efforts.
- Promote firearm safe storage.

Identify and engage existing programs/organizations/ community leaders that reach suicide vulnerable populations (e.g., church groups, county operating plans for welfare).

Assuring Support for the Plan

The Montana State Strategic Suicide Prevention Plan was presented at the Montana Public Health Association (MPHA) meeting in Great Falls on September 13, 2000.

In addition, the Steering Committee members were encouraged to have their organizations and constituents review and comment on the plan after it was posted on the web site (http://www.montanasuicide.org).

After the final review and approval of the plan by the Steering Committee, the suicide prevention plan was reviewed and approved by the Montana Department of Public Health and Human Services.

Progress Review and Plan Updates

The Steering Committee will conduct a quarterly plan review and progress update on the plan's year one action items.

Ongoing Activities

The reader is invited to visit http://www.montanasuicide.org to review ongoing activities, identity resources and explore links to prominent state and national organizations dedicated to addressing the many faces of suicide prevention.

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